PROVIDER APPLICATION/APPROVAL PROCESS

PROVIDER APPLICATION PROCESS

Individuals, Agencies, or Rehabilitation Organizations may apply to be Providers for the Adult Head Injury (AHI) Program.

Provider qualifications vary for each service, and are listed on each service description page and summarized on the AHI Program Provider qualifications section of the Provider Manual. Contact the Provider Services Representative for an application packet or visit the Special Health Care Needs (SHCN) Provider website.

The Provider Application Process is as follows:

Provider Responsibility

- Complete and return Provider Application (CC-35), Participation Agreement (DH-74A), Vendor Input and Vendor ACH/EFT Application. See instructions for assistance in completion. **Send only one per agency, not one per service;**
- Submit copies of current certification/licensure, if required;
- Maintain complete and current information with SHCN. Inaccuracies in information submitted will jeopardize application or continuation of the Provider Participation Agreement and payment of claims;
- Assure that qualified individuals are hired and trained following the guidelines for each Head Injury service for which approved.
- **NOTE: The Provider must notify SHCN if:**
    - **Business name or address changes; or**
    - **Tax ID Number changes.**

SHCN APPROVAL PROCESS

The Special Health Care Needs Provider Service Representative will process the Provider Application (CC-35), Participation Agreement (DH-74A) Vendor Input, and Vendor ACH/EFT Application in the following manner:

- SHCN will evaluate the information submitted against requirements for service(s) for which the Provider is requesting approval. This review will be completed within twenty four hours of date received;
- Any questions or incomplete information remaining upon review of material submitted will be summarized in writing, and sent by regular mail within two weeks of the date received to the Provider for a response. If possible, minor questions may be handled with a phone call;

- A signed copy of the Participation Agreement (DH-74A) and approval letter will be forwarded to the Provider when the approval process has been completed;
- Providers should allow approximately four weeks for the approval process to be completed, assuming all application forms and documentation are in order; and
- No claims will be reimbursed for services provided before the date the Provider is officially approved (date Participation Agreement is signed).

PARTICIPATION AGREEMENT
FOR PROFESSIONAL AND SPECIAL SERVICES PROVIDER
DH-74A
INSTRUCTIONS FOR COMPLETION

Complete as follows:

1. AGREEMENT NUMBER	SHCN use only.
2. O.A. VENDOR NUMBER	SHCN use only.
3. FEDERAL AGENCY NAME	SHCN use only.
4. FEDERAL AWARD YEAR	SHCN use only.
5. FEDERAL AWARD NUMBER	SHCN use only.
6. FEDERAL AWARD NAME	SHCN use only.
7. FUNDING SOURCE	SHCN use only
8. PROVIDER NAME	Enter the complete name of the agency/business.
9. NAME OF AUTHORIZED REPRESENTATIVE	Individual designated by agency.
10. SIGNATURE OF PROVIDER OR REPRESENTATIVE	Enter original signature of Provider or Representative
11. DATE	Enter the date form is completed.
12. FEDERAL TAX I.D. OR SOCIAL SECURITY NUMBER	Enter the federal tax identification number or the social security number that the Provider will use to file federal income tax.
13. TYPE OF PROVIDER	Mark the box for Type of Provider if applicable. Write in type if "other".
14. PAYMENT MAILING ADDRESS	Enter the Provider's address where payment is to be mailed to. (Street/City/State/Zip)
15. E-MAIL ADDRESS	Enter the E-Mail address of the Provider or Representative
16. STATE LICENSE NUMBER (IF APPLICABLE)	Enter the agency/individual state license number if applicable.
17. TELEPHONE NUMBER	Enter the phone number of the agency/individual Provider.
18. MINORITY OWNED/OPERATED	Mark the box yes or no if minority owned or operated business.
19. PROVIDER ENROLLMENT APPROVED	SHCN use only. **Do not mark below this section.**

Provider is to retain pink copy of Participation Agreement (DH-74A)